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DATE: March 19, 2009

TO: Government Oversight Committee

FROM: William P. Angrick II

SUBJECT: Ombudsman Presentation before Government Oversight Committee

While it has been less than a year since I last appeared before this committee to report on my activities and to offer issues and recommendations for your further consideration, many dramatic things have happened in our state. I know we are strapped for resources and yet we have major issues competing for our attention and response. The ombudsman office gets to see Iowa from a unique point of view. We hear complaints from those who are frustrated, and become advocates for change if, in our opinion, change will improve the quality of life, justice, and government service. Hopefully you will find it interesting and informative to see Iowa from our perspective.

General Ombudsman Stats for 2008

In calendar year 2008 my office fielded 4,709 contacts. Of the 4,709, 344 remain open pending investigation or closure.

This past year we saw some changes among the agencies complained of, changes which I have not yet had the opportunity to consider if they mean a systemic shift or if it just happens to be the luck of the draw this year. Other numbers and patterns remained relatively similar with the previous year.

Child Support Modification

When I was before you in June 2008, one issue I mentioned was the need to find an efficient and less costly process for parents paying support to modify their support order when their child comes to live with them. Our past effort to create an administrative modification procedure has not been successful. We continue to see this problem. Many parents faced with this dilemma can't afford an attorney to seek modification through the courts and the pro se court process created last year does not help parents if a custody order is involved (which often is the case). We appreciate that

Representative Berry took an interest in this issue and introduced a bill (HF 666) this session to create an administrative modification procedure.

Report on Use of Restraint Chairs in Iowa Jails

A significant issue my staff worked on this past year is an investigation into the issue of restraint chairs in a number of Iowa jails. A few weeks ago I published my report on that investigation in which I criticized five jails of varying sizes across our state.

Last June I shared with you some 13 general recommendations I believe should become part of our state jail standards which are found in the rules of the Iowa Department of Corrections. In my published report I made 33 recommendations in total for the five jails, including a restatement of the original general ones.
Three of the jails adopted my recommendations and two declined to do so. Among the reasons cited by one jail was because they believe what I was asking went beyond current standards required of Iowa jails. The spokesperson for another jail, speaking on behalf of a number of facilities, argued that what would be required to provide safer, healthier, and more humane restraint usage was too costly for the jails he advises.

Copies of my report are available on line and I have brought a few printed copies in case anyone prefers that format.
http://www.legis.state.ia.us/caodocs/Invstgtv_Reports/2009/CIWPA001.PDF

I have already renewed efforts to gain support among Iowa sheriffs and the Board of Corrections toward adoption of my recommendations for more specific standards relating to restraint use policy in jails.

But it is why we need restraints in jails that I want to focus on now. Restraints are needed to control inmates and detainees who are a threat to themselves and others and for whom other less restrictive controls either don't work or have been tried and failed. Many of these persons suffer from mental illness or may be under the influence of alcohol or other controlled substances or both. Of course there are some individuals who are just plain mean and choose to act violently and must be controlled.

Mental Health as a Larger Social Issue in Iowa

As I have said before this committee several times, Iowa needs to confront its failure to comprehensively establish and fund community based mental health services. It is not right that we rely upon our jails and prisons as the de facto mental health facilities of our state. One way the Legislature can work toward a solution would be to commit to the study of what a comprehensive system of community based mental health services and diversion process would entail. I'm not saying find the money now, nor necessarily commit to a particular structure or delivery process now. I'm saying commit to the study, hear the alternatives, learn about the successes and the failures, get a handle on the costs, start doing that now so you can be ready when Iowa's resources improve.

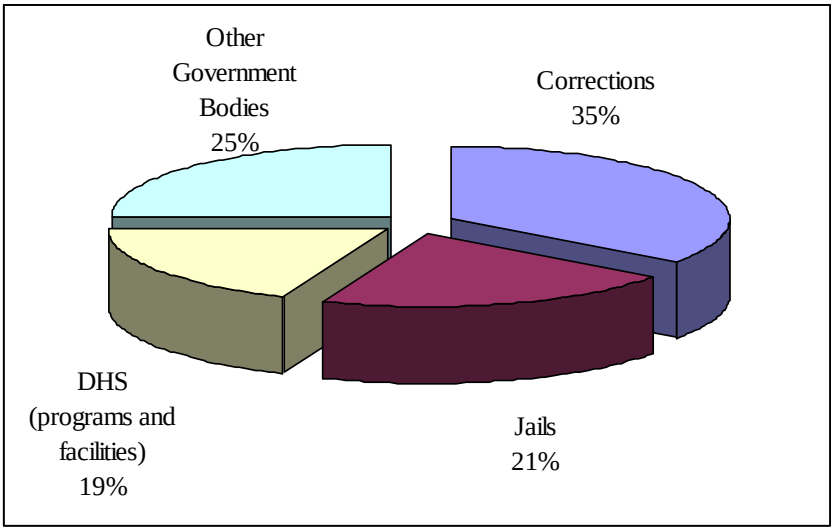
In view of our concern about mental health issues and treatment of the mentally ill, one of my assistants visited each of the Mental Health Institutes. This helped foster relationships between our staff and staff at the institutions so complaints can be handled more efficiently. We were also able to obtain information about programs and direct observation of conditions at each institution. One of my assistants also visited Glenwood to obtain first-hand knowledge of the facility and patient conditions.

My office added the ability to identify Mental Health related cases in January 2008. The purpose of adding the Mental Health "Special Topic" field was to identify how mental health issues impact complainants and complaints.

The goals are to:

1. Identify how many people claim they were adversely impacted as the result of their mental illness.
2. Identify other issues regarding delivery and availability of mental health services.

The mental health aspect of the complaint has to be articulated by the complainant or the agency. Below is a chart of the mental health related issues we received by agency in 2008.



Glenwood/DIA-P&A Meetings

My office has not received complaints about the deaths at Glenwood nor the men living in the bunkhouse at Atalissa, but we have been monitoring both situations. Since November 2008, my staff and I have been holding quarterly meetings with the Department of Inspections and Appeals, Iowa Protection and Advocacy, and ARC of Iowa where we discuss issues surrounding Glenwood and other facilities. We plan to invite a representative of Department of Human Services to our next scheduled meeting.

Based upon our discussions during one of these meetings, I became concerned whether the revisions to the Iowa law requiring a Preliminary Death Investigation by the County Medical Examiner [upon the death of a person confined to a state resource center] were being followed. In the legislation proposed by my office and adopted last year, DHS institutions are now required to report deaths of their residents to the county medical examiner who is to file a preliminary death investigation report to the State Medical Examiner. We obtained lists of the deaths at state institutions since July 1, 2008, and met with the State Medical Examiner's office to ensure they received reports on each of the deaths. The majority of deaths were reported. Two of the deaths actually occurred in Nebraska and neither the county medical examiner nor the Iowa State Medical Examiner has jurisdiction to require an investigation or an autopsy on such out of state deaths.. We are still investigating why preliminary death investigations were not undertaken on the other three deaths.

One idea we will be discussing in our quarterly meetings is whether a death review team is necessary for people who die in state run or state licensed facilities. The Preliminary Death Investigation process does not necessarily detect systemic issues such as poor nursing care or staff failing to supervise patients. We are researching Iowa's child death review team and domestic violence death review team, as well as other states death review teams, relating to deaths of persons who are mentally ill or developmentally disabled.

Civil Commitment Issues/CPC Survey

We received a complaint from a jail administrator that an inmate was injuring himself and attempting suicide. The jail administrator had tried to obtain help for the inmate through the Mental Health Civil Commitment process. The judge refused to order commitment until placement could be found and it was unclear who was to find placement. We initially believed it was the responsibility of the County Central Point of Coordination administrator (CPC) to find placement. My staff suggested several placement options to the CPC and eventually the inmate was placed. We reviewed the law regarding commitments and found the law does not specify who is responsible for finding placement. While investigating the restraint chair case, we noted at least two counties where there were issues with civil commitment. You will note in the restraint chair report that Jefferson County officials were reluctant to try a mental health civil commitment of TH because they believed the judge would be unwilling to order the commitment. No attempt was made to commit the Woodbury County inmate, however, he was sent to the IMCC at Oakdale for a mental health evaluation.

We decided to survey the county CPCs to see what issues they were having with the commitment process. We received responses from 70 of the 99 counties. Responsibility for placement varied widely. In many counties the CPC is responsible for finding placement, but they have difficulty obtaining all necessary information from the District Court Clerk's office. Doctors and hospital staff often have questions the CPC can't answer if the family has only spoken with the district court clerk and judge. District court clerks in many counties will not assist with placement because they have been told

by their chief judge not to, due to lack of funding. In Poweshiek County the family or the patient is responsible for finding placement. There are a few counties where placement is a cooperative effort between the clerk's office, the CPC and the community mental health center. Placement works most smoothly in these counties. Almost all counties reported problems finding placement citing a lack of mental health inpatient beds.

Go Beyond Mental Illness; Include the Mental Retardation/ Developmental Disability

This challenge goes beyond mental illness, it includes our programming, services, and protection for the mentally retarded and developmentally disabled. As we have just heard, you may not be able to fully investigate now the particular stain of Atalissa, but you can address the issue in other ways.

We have known that for several years our state schools at Glenwood and Woodward have been having problems, failing federal inspections. There is nothing preventing you from examining those circumstances, and in your consideration of alternatives for those institutions to take on the issues impacting boarding house conditions as found in Atalissa. I think it also might be timely to expand beyond boarding house and to include an examination of the living conditions for migrant labor in Iowa

What would happen if there is a successful lawsuit that calls for the closing down of Glenwood? What needs to be done if the legislature or the governor decide, as a policy decision, to shut those school doors? Where would the residents go? Does Iowa have sufficient local level housing and support services? Have we promulgated the standards, can we identify the housing and where they are, what kind of licensing and inspections would be needed? This committee can continue to bring in the officials and stakeholders to provide you that information now rather than wait until a later date: Iowa Protection Advocacy (P &A); the Iowa chapter of the National Association for Mental Illness (NAMI); Iowa Department of Inspections and Appeals; ARC of Iowa; Iowa Department of Human Services; and our county governments, especially the Central Point of Coordination would, in my opinion, be prime candidates for those invitations.

Do we have a sufficiently effective commitment process in our state? Some studies in the judicial branch suggest that system should be clarified and can be streamlined. I think your review of those findings would be valuable. Additionally for some time now the DHS has coordinated an Acute Care Task Force. Staff from my office has been participating in those meetings. Again I think an invitation for a spokesperson from that task force would be of interest to the larger considerations of the Government Oversight Committee.

A Single Point of Contact has Been Called for Since at Least 2000

As many of you may recall, in 2000 my office published a report about the failings in the DHS child protection system after the tragic death of Shelby Duis. In 2003 my office published a report about the unsuccessful transitioning of Reggie Kelsey out of Iowa's

foster care system. Many of the Duis report core recommendations are relevant to the response to the Atalissa situation. The Reggie Kelsey findings and recommendations are less so, but they do underscore a need for coordination and communication across agencies and levels of government.

I have prepared for distribution printed copies of the improvements suggested by DHS to its dependent adult abuse process at a recent Dependent Adult Abuse Task Force meeting. I also provide you the relevant recommendations from my 2000 Duis report. At the time DHS balked at what they estimated the costs of establishing a single point of contact. In the Duis report my office recommended:

1. The Department of Human Services (DHS) redesign the child abuse reporting system so that:

    a. **Reporters have a single point of contact which they can be instructed to call, regardless of where they live, the time of day, or the county, cluster or region having responsibility to evaluate the report.**
    b. Reporters are able to speak with an intake worker during their initial call.
    c. All report information, regardless of who initially receives the report, be promptly documented and retained, timely routed, and appropriately evaluated.

I remain firm in my belief that a single point of contact for all child welfare, and now dependent adult, abuse complaints would be of paramount importance toward reducing the risk of reoccurring tragedies and embarrassments.

Public Records, Open Meetings, and Privacy

Public records, Open Meetings, and Privacy (PROMP) issues are a special interest to my office. We have been offering a specialization in these issues for a number of years and have noted an increasing number of questions and complaints coming our way during that time. The challenges of transparency and privacy are interrelated, intertwined. Law and policy should be developed as a whole, not in opposition or separately.

The legislature has invested in a multi year review to overhaul our public records and open meetings laws, and to consider how to better provide effective and timely enforcement of violations of those laws. My staff and I have continued to participate in that process beginning with the 2007 Interim Study committee through the current day.

In addition to the omnibus reform legislation that is progressing, I know that more challenges and changes will be happening on a continual and accelerating basis. Foremost among those challenges is the impact of electronic record keeping and data collection. I do not believe the omnibus legislation being considered will address these challenges. They are mighty and I urge continued sensitivity to the challenges and opportunities electronic data presents our state and its governments. For example: Should information be available in bulk? Should it be posted to a website for all to

access? If posted should it be searchable? In a format so it can be manipulated by the user? The County Recorders Land Records issue from last autumn is currently being addressed by legislation. The questions, issues, and policy choices that are presented by the electronic public records need inventory, examination, and consideration. Are we collecting too much sensitive information? Do we have adequate safeguards to protect citizens when records are lost, hacked, or otherwise compromised? Do we properly dispose of records when no longer of use? This is one of the reasons I have proposed, as part of the omnibus public records and open meetings legislation, the establishment of a multimember advisory committee which would meet regularly to address issues of public import and which require policy or legislative decisions.

Citizens' Aide/Ombudsman Public Records, Open Meeting, and Privacy	2004	2005	2006	2007	2008	Five-Year Average
Complaints	116	150	173	206	184	166
Information Requests	67	106	99	98	107	95
Total	183	256	272	304	291	261

IOWA SUPREME COURT'S LIMITED JURISDICTION TASK FORCE
Dated December 15, 2008

Entire report available at: http://www.iowacourts.gov/wfdata/frame6845-1152/File33.pdf

From page 3 of report:

Recommendation 10

Amend the Iowa Code to authorize the Supreme Court to issue rules that would allow physicians to implement a temporary hold on a patient needing a mental health or substance abuse committal between the hours of 10:00 p.m. and 7:00 a.m.

Recommendation 11

Establish a joint task force including representatives from, but not limited to, the Judicial Branch, the Department of Human Services, the Attorney General's office, the Department of Corrections, and Central Point Coordinators to study and recommend improvements to mental health and substance abuse committal policies.

From page 14 of report:

5. There are urgent and serious problems which need to be addressed by the stakeholders involved in our mental health system relating to emergency mental health commitments.

One of the issues of greatest concern to the Task Force involves the handling of mental health and substance abuse commitments. It is clear to Task Force members that problems in this area go far beyond the capacity of the judicial branch or any other department or agency to address and solve alone. Although funding is clearly one of the major issues in improving the system, it seems evident that there are ways to improve the system without a significant increase in funding. The Task Force concludes that this will only occur if addressed by all of the major stakeholders working together.

From page 23-24 of report:

Recommendation 10

Amend the Iowa Code to authorize the Supreme Court to issue rules that would allow physicians to implement a temporary hold on a patient needing a mental health or substance abuse committal between the hours of 10:00 p.m. and 7:00 a.m.

A phone call from a physician with an emergency mental health or substance abuse committal patient is one of the most-frequent late night interruptions for magistrates or other judicial officers who are on-call. Late night requests for a committal order are almost always granted by magistrates if the committal is recommended by a physician.

Consequently, requiring a patient to wait for a judicial order until 7:00 a.m. the next morning is not an undue burden. By making this code change subject to Supreme Court rule, there would be judicial oversight and procedures in place, including the option of not exercising this authority at all.

Improve the Mental Health and Substance Abuse Commitment Process

Recommendation 11

Establish a joint task force including representatives from, but not limited to, the Judicial Branch, the Department of Human Services, the Attorney General's office, the Department of Corrections, and Central Point Coordinators to study and recommend improvements to mental health and substance abuse committal policies.

Of all the matters studied by the Task Force, none appear more complex and in need of immediate change than Iowa's mental health and substances abuse committal policies and practices. Most of what the Task Force heard and discussed on this topic cannot be addressed solely by the Judicial Branch. The issues involve multiple state and county departments as well as the courts. Placement options, adequate staff, transportation options for children with parents, sheriff office travel costs, and stand-by obligations are just a few of the issues and concerns. It is important to note that many possible changes could be revenue neutral or even result in savings for the state and counties.

The Task Force believes that addressing these issues as soon as possible is critical if Iowa is to provide adequate services to its citizens on an efficient and cost effective basis. The Task Force calls on state leaders to create a joint commission study group to study and address these problems and issues.

Presented by the Department of Human Services to the Governor's Task Force on Dependent Adults with Mental Retardation on March 6, 2009. Available at: http://www.state.ia.us/elderaffairs/Documents/DependentAdultTF/Materials/March%206/IADepAdultProtectiveSystemDHS.pdf

Iowa's Dependent Adult Protective System

Guiding Values for a Dependent Adult Protective System:

- Choice for the Person
- Safe and Healthy Living Situations
- Maximum Independence
- Families and communities are integral to the safety of dependent adults

Iowa's Dependent Adult Protective System should:

- Be proactive
- Include prevention, early intervention and intervention services
- Have a common understanding of who is a dependent adult
- Make key services and supports available and accessible
- Measure and publish system performance
- Support independence and choice while assuring safety
- Recognize interdependency among many to make it work
- Promote the least restrictive service intervention

Action Steps to Improve Iowa's Dependent Adult Abuse Assessment Process

DHS Dependent Adult Abuse Intake Process:

We have reviewed our existing intake system and based on this review we have identified the following actions.
Within 30 days:

- Provide training to all intake staff regarding intake definitions and responsibilities
- Provide training to all staff on what to do when receive calls relating to dependent adult abuse staff.
- Implement a quality assurance system to ensure intakes reach accurate decisions and are consistent.
- Issue a written notice to all reporters on accepted or rejected intake

Within 60-120 days

- Revise Dependent Adult Abuse Staff manual to clarify processes, definitions and decision points.
- Review and revise information and referral process (must have Code change)
- Convene a stakeholder group to review definition of dependent adult and caretaker for potential revisions
- Implement an automated dependent adult management information system

Recommended Statutory Changes

- Amend Chapter 235B.9 to retain rejected intake and unconfirmed reports for 5 year.

- Amend Chapter 235B.6

Presented by the Department of Human Services to the Governor's Task Force on Dependent Adults with Mental Retardation on March 6, 2009. Available at: http://www.state.ia.us/elderaffairs/Documents/DependentAdultTF/Materials/March%206/IADepAdultProtectiveSystemDHS.pdf

DHS Dependent Adult Assessment Process:

We have reviewed our existing intake system and based on this review we have identified the following actions.

Within 30 days

- Assure consistency of contact with the Medicaid Targeted Case Managers and other established Case Managers
- Assure appropriate coordination with the Division of Mental Health and Disability Service and Iowa Medicaid Enterprise for review for accreditation standard or certification requirement violations.

Within 90-180 days

- Identify/develop and implement standardized assessment tool to assist staff in determining dependency
- Identify and implement a tool to guide next steps at the conclusion of an assessment process

Services:

Public Awareness

Within 30 days

- Share with DHS Service Area Advisory Boards, County Central Points of Coordination , key providers and other key stakeholders information including key contact numbers and basic referral guidelines for dependent adult concerns.

Within 60-120 days

- Meet with Service Area Advisory Groups, County Central Points of Coordination and other key groups to identify gaps in programming for dependent adults.

Create greater shared responsibilities through the development of Community Partnerships for Dependent Adults. (Requires an appropriation)

Within 90 days

- Convene stakeholders to a statewide conversation to develop a model for community partnership for dependent adults. Community Partnership is designed to enhance a community's capacity to provide a safety net of services and formal and informal supports for vulnerable adults.

Within 180 days

- Implement a Pilot Community Partnership

Presented by the Department of Human Services to the Governor's Task Force on Dependent Adults with Mental Retardation on March 6, 2009. Available at: http://www.state.ia.us/elderaffairs/Documents/DependentAdultTF/Materials/March%206/IADepAdultProtectiveSystemDHS.pdf

Create Transitional Case Manager. (Requires an appropriation)

Within 60-90 days

- Determine method for implementing Transitional Case Management Services for persons who have been abused and do not otherwise have an ongoing case manager to who will be responsible for coordinating natural supports or community services to assure the individual will remain safe. This person will facilitate the integration into ongoing services and is necessary for a period of time after services for a period of time between initial assessment and ongoing services.

Establish a Dependent Adult Safety Services Adult Appropriation.
Establish an appropriation to provide for safety services for consumers not otherwise eligible for services. The appropriation may be used for Transitional Case Managers to arrange for services, emergency housing, medical care, and supports. The appropriation may also be used to meet the necessary costs of community collaborations.
The cost components:

- Public Awareness
- Information management and reporting for public accountability and transparency
- Community collaboration and public awareness of dependent adult abuse
- Safety independence planning and service arrangements in partnership with the dependent adult the community, and the family. The case manager will continue to monitor and evaluate service as needed.
- The provision of services not otherwise funding for basic needs and services focused or the safety of independent plan.

The estimated annual cost will be provided on 3/12/09.

Strengthen existing Adult Multidisciplinary Team

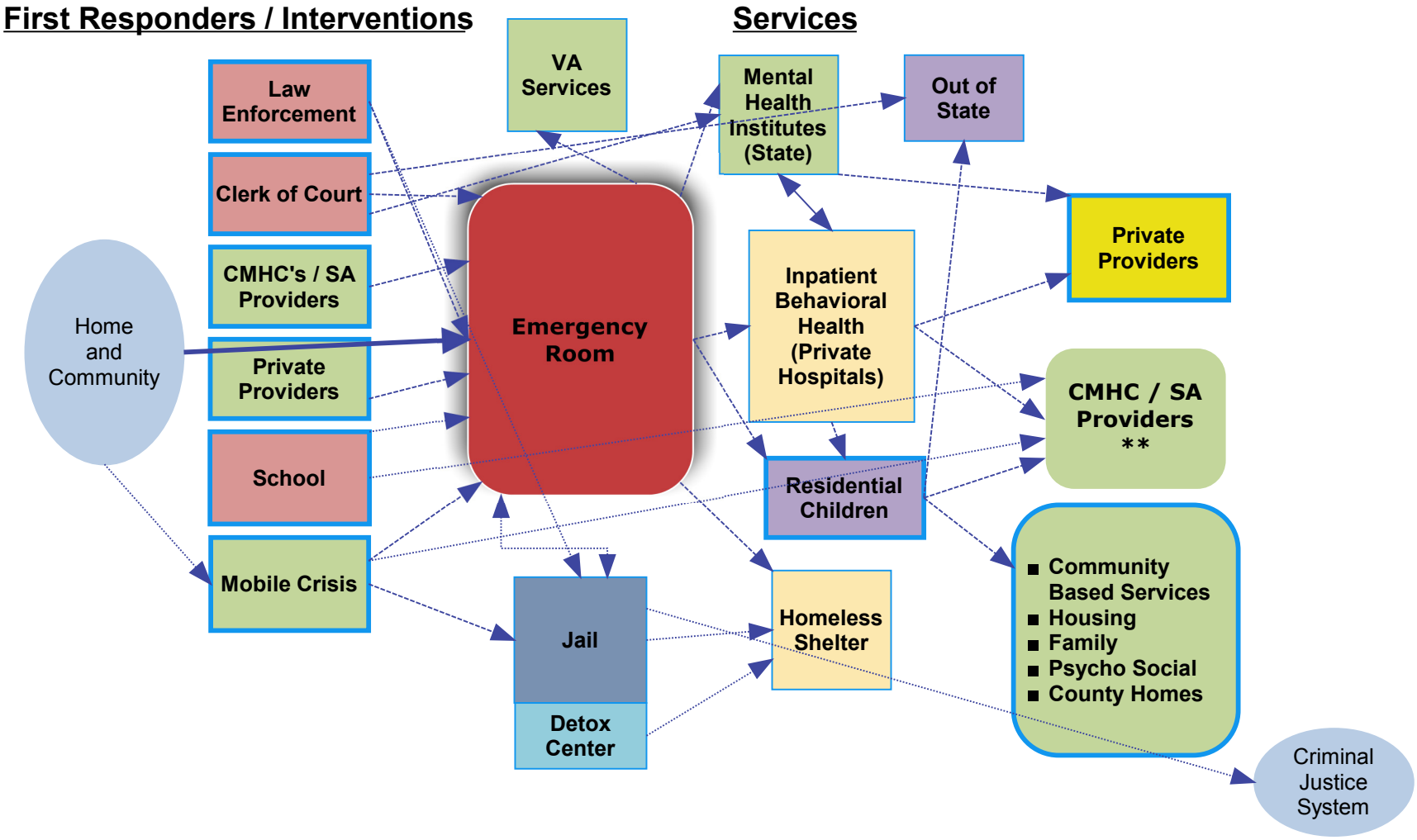
` Within 120 days

- Assess existing use and effectiveness of Multidisciplinary Teams
- Identify and implement changes to improve

Strengthen DHS Accreditation and Certification requirements for providers

Within 180 days

- Implement enhanced provider requirements for identifying and reporting potential consumer safety issues
- Implement enhanced provider requirements for training regarding consumer safety



Emergency Acute Care System Flow in Iowa, April 2008

** Waiting list exists for certain services.
CMHC = Community Mental Health Center
SA = Substance Abuse Providers
VA = Veterans Administration

Draft of the Acute Care Task Force